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# An Investigation of Changes in Anxiety Level Following Consideration of Death in Four Groups.

Pamela Reynolds Hoblit

*Louisiana State University and Agricultural & Mechanical College*

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AN INVESTIGATION OF CHANGES IN ANXIETY LEVEL FOLLOWING  
CONSIDERATION OF DEATH IN FOUR GROUPS

A Dissertation

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
in partial fulfillment of the  
requirements for the degree of  
Doctor of Philosophy

in

The Department of Psychology

by  
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## ABSTRACT

The purpose of this research was to determine whether the consideration of death arouses anxiety and to measure differences between four groups on the level of anxiety and conscious concern about death. Subjects were all males, ranging in age from 20 to 60 years; three of the groups were in-patients at the Veterans Administration Hospital and the other group was hospital employees with minimal contact with patients. The four groups were chosen on the basis of their different positions of expectancies for personal death. Cancer patients were a group who were aware of the cancer diagnosis and for whom there was an awareness of death as a present, unavoidable factor; medical patients were a group with minor medical problems for whom it was assumed there would be some concern because of the health problem and hospitalization, but for whom death was not an immediate threat; healthy individuals were a group of nonpatients for whom it was assumed there was awareness of the existence of death but it was not yet personalized or of vital concern; heroin users were a group of patients hospitalized for a drug related problem for whom there was an awareness that death might follow any injection, and if not no threat of death existed until the next injection. The heroin users were included because this group frequently voiced a particularly nonchalant, almost flirting attitude toward death, admitted to being aware that their drug purchases might be contaminated, unusually powerful, or otherwise likely to result in overdose and death.

It was hypothesized that consideration of death would increase the level of anxiety in all groups and that the level of anxiety and death concern would be greatest for the cancer patients, followed by the medical patients, next the healthy subjects, and that the heroin users would show the smallest increase in anxiety and the lowest death concern.

The results indicated no increase in anxiety following consideration of the subject of death and no significant differences between groups on death concern or level of anxiety. The research suggested that people, even cancer patients, may have a much more casual, accepting attitude toward death than is generally thought.

## INTRODUCTION

Man has always been forced to cope with and experience death. Artists, theologians, and philosophers have long explored images, perceptions, and meanings of death. Within the past two decades other investigators have begun to explore behavior associated with death and dying; psychologists, psychiatrists, social workers, doctors, nurses, clergy, sociologists, and anthropologists are examining how individuals are affected by the existence of death.

Most investigators feel that the cultural norm of America is to attempt to deny the reality of personal death and treat death as a taboo topic (Feifel, 1963; Kazzaz and Vickers, 1968; Howard and Scott, 1965). In essence, death is a forbidden topic regulated with euphemism and impersonal ritual (Weisman and Hackett, 1961) with a wall built against healthful discussion of the subject (Bowers, et al., 1964). There is, therefore, a limited understanding of death and its effect on individuals (Flock and Nie, 1959). Not only is death a taboo topic, but as Gorer (1960) pointed out, grief is stigmatized as morbid and unhealthy, and because the bereaved are offered little support they suffer misery, loneliness, despair, and may often exhibit maladjusted behavior.

Based on review of literature on death and dying two general conclusions could be drawn. First, that death is regarded as a taboo topic. The second observation is that it has been difficult to produce systematic, experimental evidence for the existence of anxiety aroused by the topic of death.

Supporting the contention that death is an anxiety-provoking topic are the observations of researchers on the difficulties encountered as they attempted to investigate the area. Feifel (1963) met great resistance and felt that "death is a dark symbol not to be stirred or even touched, an obscenity to be avoided." He also found that 69 to 90 per cent of physicians (depending on the specific study) said that patients ought not be told that they would probably die of their present disease (Feifel, 1963). Other researchers in hospitals also met staff resistance, disapproval, and hostility at least initially (Saunders, 1969; Quint, 1965; Ross, 1969). Glaser and Strauss (1965) found that hospitals frequently maintain a system of closed awareness to prevent a patient's becoming aware of impending death.

Dealing with death and dying was seen as extremely stressful for dying patients, doctors, nurses, families, and other health care professionals (Bakke, 1960; Baker and Sorenson, 1963; Tourney, 1969; Kazzaz and Vickers, 1968; Waxenberg, 1966). Evasions and poor communications were found consistently, particularly over informing the patient of a terminal condition (Duff and Hollingshead, 1968; Oken, 1961; Quint, 1965; Glaser and Strauss, 1965, 1968; Koenig, 1969). Even psychotherapists and clergy often tended to avoid the dying patient (LeShan and LeShan, 1961; Bowers, et al., 1964). These studies are observational; what is needed are more studies which can be replicated and further explored.

Investigators have observed and listed numerous fears aroused by the idea of death: fear of unknown, fear of loneliness, fear of

loss of family and friends, fear of loss of body, fear or loss of control, fear of loss of identity, fear of regression (Pattison, 1967; Becker and Bruner, 1931). It is easy to agree that death is an anxiety-provoking topic and Feifel (1969, p. 292) flatly stated that "consideration of death is undoubtably one of the foremost sources of anxiety for man." However, as will be seen in the next section, establishing the validity of this statement has proven difficult and data at this time are inconclusive.

#### Death Anxiety in Normal Populations

Most studies where methods such as direct questioning were used had elderly subjects, although there are a few which employed college students and randomly selected adults. On the other hand studies with indirect methods of investigation have generally been conducted with college students.

#### Data from direct techniques

Investigators of attitudes and fears of a normal population concerning death have often used questionnaires; generally responses indicated little fear. Middleton (1935) administered an extensive questionnaire to 825 students; 92 percent reported thinking of their own death rarely or occasionally and 62 percent reported feeling indifferent attitudes toward death, with only 12 percent admitting to a strong fear. In a sample of 1482 adults (Riley, 1970) 32 percent never thought of death and 32 percent often thought of death, compared to 76 percent who thought of their health often and 4 percent never.

During this survey Riley observed that subjects were willing to talk about death. His general conclusion was that in contemporary American society, concern with death prompted people to think of others far more than it provoked anxiety about self.

Jeffers (1961) studying 254 volunteers over 60 years old found that ten percent responded affirmatively to the question "Are you afraid to die?" Thirty-five percent answered negatively and the rest negatively with some qualification.

Many older persons seemed to accept death positively. Swenson (1961) found in a population of 210 people over 60 years old, 82 persons looked forward to death, 71 were actively evasive about death, and 57 about equally divided between the two attitudes.

Kastenbaum (1966) who has done much work in this area, reported having rarely encountered among aged patients any obvious indication of "death fear."

#### Data from indirect techniques

Most investigators believed that people deny their overwhelming concern with death and regarded direct questioning concerning consciously expressed attitudes as inappropriate. Alexander, Colley, and Adlerstein (1957) exposed a male undergraduate sample to words related to death and measured response time, psychogalvanic response, and response words. Conclusions drawn from the data were that subjects responded to words related to death with greater emotional intensity than to equivalent words drawn from a general language sample. They suggested that there are two levels of functioning, conscious and less

conscious. In some individuals there is agreement between responses on both levels; in others a wide discrepancy may exist.

Meissner (1958) also using GSR measures found significant differences in mean responses between death words and nondeath words for subjects ages 23 to 40 years. He concluded that death symbol words elicited at least unconscious affective reaction.

Another indirect method has involved use of the tachistoscope. Golding, Atwood, and Goodman (1966) with 304 students found that mean trials to recognition was greater for death words than for neutral words.

Interview techniques with college students indicated that affective responses in general are increased when discussing death and the predominant increase occurred in the category of negative affect (Greenberg and Alexander, 1962).

Handal (1969) used another indirect method which required subjects to make an estimate of their own life expectancy. He found a significant negative relationship between subjective life expectancy (SLE) and death anxiety in females and regarded SLE as a critical indicator of attitudes toward death, whereas for men it appeared to be a manifestation of a defensive attitude toward life.

#### Demographic variables and attitudes

Attempts have been made to explore relationships between death attitudes, anxieties, and various demographic variables. Overall, a great deal of conflicting and inconclusive data has been accumulated, perhaps due to use of different techniques and populations.



Education.--Data from older persons indicated that there is a trend for less educated people to be evasive about death, those with a college education to express more specifically either looking forward to or fear of death (Swenson, 1959, 1961). Others have found no relationship between high death concern and education in older people (Rhudnick and Dibner, 1961; Christ, 1961).

One study with high school students (Mauer, 1964) also found that poor achievers associated death with greater fear and found it difficult to express their thoughts while the top 10 percent scholastically expressed acceptance of the inevitable and determination to live a full life.

Religion.--The influence of religious orientation to death concerns has been difficult to determine. Jeffers (1961) found fear of death associated with less belief in after-life and less frequent Bible reading in subjects over 60 years old. Swenson (1959, 1961) studying individuals over 50 years old found significant relationship between religiosity and attitude toward death; fearful attitudes tend to be found in persons with less religious activity. However, Templer and Dotson (1970) working with 213 college students found no significant relationship between Death Anxiety Scale scores and several variables of religious affiliation, belief, and activity. Martin and Wrightsman (1964) found that adult church members who reported great religious participation indicated less fear of death on several measures; however, Feifel (1959) found that religious subjects were more afraid of death.

Alexander and Adlerstein (1959) studying religious and non-religious college males found that both groups experienced increased GSR to death words and both groups were very much alike in consciously expressed attitudes toward death in that both expressed little concern about death. More nonreligious subjects regarded death as the natural end of life and their psychological reaction to death involved masking--being wholly occupied with no time to reflect about death--and repression. The religious group focused on after-life and death was a more conscious matter.

Health.--Cappon (1959) found that disease whether somatic or psychiatric increased frequency of statements of fear of death. Swenson (1959) found that older persons in good health are actively evasive; those with poor health looked forward to death in a positive manner.

Occupation.--Most studies found no relationship when studying older subjects (Rhudnick and Dibner, 1961; Swenson, 1959). Stacey and Martin (1952) administered a long questionnaire to prisoners, engineers, foresters, and lawyers, and observed 111 significant differences concerning thoughts about death, attendance at funerals, desire to live after death, among many other things. However, this study is difficult to interpret and to determine different levels of fear of death.

Marital status.--With older subjects Rhudnick and Dibner (1961) found no difference, but Swenson (1959) found that widowed, older persons have an actively evasive attitude, while single, separated, and

married older persons tend to look forward to death.

Sex.--Some investigators found no relationship, but these usually involved older subjects (Rhudnick and Dibner, 1961; Swenson, 1959). Diggory (1966) found that pain of dying is feared more by women and concern over dependents was feared most by men. Both were equally concerned that all their plans and projects would come to an end. Tolor and Murphy (1967) suggested that women are more accepting of reality of death than men.

Age.--There are no systematic, developmental studies. Diggory (1966) did consider the variable of age and found that concerns varied according to age with all age groups expressing major concern over the grief death would cause friends and family and the major differences being that age groups from 15-19, 20-24, 25-39 expressed more concern over the end of plans and projects and fear of the pain of dying and older groups 40-54 and over 55 expressed most concern over care of dependents. Riley's survey (1970) indicated that older Americans took a more active approach toward death in terms of making wills and funeral arrangements. Corey (1961) found that younger subjects coped with death more frequently by acceptance and neutralization, while an older sample more frequently showed avoidance.

### Personality traits

Few studies have been conducted relating death anxiety with personality traits. Tolor and Reznikoff (1967) using Byrne-Repression Sensitization Scale and a death anxiety scale devised for the study

with college students as subjects found high death anxiety associated with sensitization defenses. However, Paris and Goodstein (1966) found that sensitizers did not verbalize more anxiety after reading material on death. Templer (1970) found that scores on his Death Anxiety Scale correlated with the MMPI scale measuring psychopathic behavior ( $r = -.27$  with Pd) and a scale measuring social introversion ( $r = .25$  with Si).

An interesting suggestion has been made that a person who is convinced that he has had a full life is ready to die with little anxiety (Hicks and Daniels, 1968). This hypothesis has not been explored. A somewhat related idea, that a person with high ego strength would have low death anxiety, was not confirmed in a study with college students (Greenberg and Alexander, 1962).

### Meaning of death

Feifel (1959) found two main images of death; death as a natural end of the process of life and death as the beginning of a new life. In Riley's (1970) survey of a normal population, 54 percent saw death as a long sleep, 82 percent saw death as not tragic to the person who dies but for survivors.

Murphy (1959) reminding that fear of death is not psychologically homogeneous offered this list of images and fears: death is the end, fear of losing consciousness, fear of loneliness, fear of unknown, fear of punishment, fear of abandoning dependents, fear of failure. Other images are corpses, decay, coldness, isolation, peace, violence and destruction, stench, grief, rebirth, reunion. Certainly measures of

death attitudes and anxiety tap a many faceted concept. Collett and Lester (1969) have conducted research which indicates at least four separate fears: 1. fear of death of self, 2. fear of death of others, 3. fear of dying of self, 4. fear of dying of others. Subjects had higher fear of death than of dying and greater fear when self was referent than when others were referent.

Diggory and Rothman (1969) found that most frequently mentioned values threatened by personal death were experiences, plans and projects, and caring for dependents. Also subjects often mentioned concern for the grief relatives and friends would feel. Less frequently mentioned were uncertainty over fate of the body, concern over after-life, and concern that dying process might be painful.

Feder (1965) suggested that people are unable to conceptualize the terrors of death in a way that has any real meaning. He felt that the concern of his cancer patients was the fear of being hurt or deserted.

#### Summary of methods

The most frequently used method has been questioning directly, with most investigators devising questions for the study (Stacey and Martin, 1952; Jeffers, et al., 1961; Feifel, 1955, 1957; Christ, 1961; Middleton, 1936). Others have devised their own "fear of death" or "attitude towards death" scales (Livingston and Zimet, 1965; Sarnoff and Gowin, 1959; Collett and Lester, 1970; Templer, 1970; Swenson, 1961). Most of these scales involved statements to which a true-false answer is given. Templer (1970) is somewhat exceptional in presenting

reliability, and validity measures for his scale, as well as explaining its construction. Some of the confusion in death research is a result of lack of refinement and further validity studies on scales and paucity of research using each scale.

Other verbal measures have involved essay (Mauer, 1964); use of TAT cards to elicit death anxiety (Rudnick and Dibner, 1961), interviews (Hinton, 1963; Greenberg and Alexander, 1962), and reading death passages from literature and reporting level of arousal (Paris and Goodstein, 1966).

Physiological measures such as psychogalvanic skin response have been used (Alexander, Colley, Adlerstein, 1957; Meissner, 1958). Numerous other indirect techniques have been used, producing unremarkable data which is often difficult to interpret (Blatt and Quinlin, 1967; Dickenstein and Blatt, 1966; Lester, 1967; Fast and Paul, 1970; Tolor and Murphy, 1967).

Only one study was located which attempted to induce death anxiety in normals and measure the increase in anxiety. To determine the validity of his Fear of Death Scale (FODS) Boyar (1964) administered the scale before and after a movie intended to increase death anxiety. The FODS scores for the experimental group increased to a significantly greater extent than those of the control group shown a relatively innocuous movie.

In conclusion, it seems that most subjects reported little anxiety over death and infrequent thoughts on the subject, but some subjects did exhibit physiological arousal when dealing with death

words and more negative affective words in interviews concerning death. To some extent these findings may be the result of a cultural norm discouraging reflection on personal death. As a person is threatened by illness perhaps death concern will increase and death anxiety may be expected to be higher.

#### Death Anxiety in Patient Populations

A great deal of research on attitudes toward death in patients has been done with acute geriatric patients, often in psychiatric hospitals. The data indicate that the majority have thought and talked little about death and report little fear of dying (Haider, 1967; Christ, 1961; Roberts, et al., 1970). This lack of fear may represent loss of interest in life, loss of contact with reality, or inability to think clearly. Perhaps these findings should be considered in the same framework as Norton (1969) interpreted lack of anxiety in kidney failure patients: what is often called denial in the face of death represents cognitive unreadiness or inability to deal with generalities of life.

Hinton (1966) found that dying patients who were younger than 60 years and patients who had dependents were more distressed over dying. Hinton (1963) comparing dying patients to seriously ill patients found that the dying had significantly higher incidences of unrelieved physical distress. On the basis of interviews he found that the dying more commonly were depressed and more anxious. Such a study needs replication using a more objective or least quantifiable measure of anxiety level.

Feifel and Jones (1968) studying four groups (92 seriously and terminally ill patients, 94 chronically ill, 90 mentally ill, and 95 healthy individuals) found that 71 percent of all groups denied fearing death. Denial seemed to be the main coping technique to deal with the idea of personal death. Anxiety and depression characterized the seriously and terminally ill more than the healthy, who used intellectualization.

As mentioned earlier Cappon (1962) studying conscious, formalized attitudes to death and dying found that in general disease whether somatic or psychological increased frequency of statements on fear of death. But the nearer a person came to actually dying--those dying from cancer--the more frequently statements changed from direct to indirect expressions of fear of death and dying.

The expectation is, therefore, that anxiety level is higher in medically ill and terminally ill than in normals unless the patient is aged.

Chandlers (1965) has suggested three positions of reference toward death which may be relevant. 1) Existence of death--awareness that death exists, but is not yet personalized or of vital concern; 2) presence of death--knowledge that one has an incurable terminal disease; and 3) presentment of death--recognition that death may occur at any moment or that one may live longer than expected.

The findings generally have been that people in the first position, healthy people, report little anxiety over death and infrequent thoughts on the subject, but may exhibit physiological arousal when dealing with death words. Observational studies of patients who are in



the second position indicated a great number of fears, concerns, and behavior which may include regression, withdrawal, repression, irritability, obsessive-compulsiveness, and feelings which include anxiety, grief, depression, guilt, shame, anger, and a great sense of isolation (Tourney, 1969; Rosenthal, 1957; Hackett and Weisman, 1969; Pattison and Mansell, 1967).

#### Statement of the Problem

More data is needed concerning the level of anxiety aroused by thoughts of death. Research suggested that subjects drawn from different health populations will experience different levels of anxiety over death thoughts (Cappon, 1962; Feifel and Jones, 1968; Hinton, 1963; Chandler, 1965). However, little systematically gathered data is available. It is the main purpose of this study to identify persons who have different positions of expectancies for personal death and to compare the difference between these groups on level of anxiety experienced after considering the subject of death. A modified version of Chandler's three processes of dying was used (1965). The first group was healthy individuals for whom it was assumed that there was awareness of existence of death, but it was not yet personalized or of vital concern; medical patients comprised the second group; for these patients, hospitalized with a minor medical problem, it was assumed that there would be more concern because of the health problem, but death was not an immediate threat; the third group consisted of cancer patients, informed of the existence of an incurable cancer; for this group there would be awareness that death was a present, unavoidable

factor; the fourth group was hospitalized heroin users for whom it was assumed that there was awareness that death might follow any injection, and if not, no threat of death existed until the next injection. The heroin users were included because this group frequently voiced a particularly nonchalant, almost flirting attitude toward death, admitting to being aware that their drug purchases might be contaminated, unusually powerful, or otherwise likely to result in over-dose and death upon injection. Therefore, it was hypothesized that this group would manifest less anxiety concerning the subject of death.

The hypotheses for this study were:

1. For all four groups consideration of the topic of death increases the level of state-anxiety.
2. Subjects with different expectancies for personal death regarding time of occurrence will experience different levels of state-anxiety increase with:
  - a. Heroin users--smallest increase because they repeatedly and by choice face the possibility of death.
  - b. Healthy subjects--increase greater than for heroin group, but less than for other groups, because death is a threat but is regarded as an event remote in time.
  - c. Medical patients--increase greater than for healthy and heroin groups, but less than for cancer patients, because individuals threatened by physical illness will be likely to become concerned about failure of the body to function correctly and to regard death as an event having a greater probability of occurrence than do healthy individuals.
  - d. Cancer patients--greatest increase in anxiety after considering death, because they face death which they cannot avoid.
3. Scores on the Death Anxiety Scale will be different for the four groups, with:

- a. Heroin users--lowest.
- b. Healthy subjects--greater than for users, but less than for the other two groups.
- c. Medical patients--greater than for heroin and healthy groups, but less than for cancer patients.
- d. Cancer patients--highest.

## CHAPTER II

### METHOD

#### Subjects

Subjects were male, aged 20 to 60 years, seen in the Veterans Administration Hospital in New Orleans, Louisiana. There were four groups with 12 subjects in each group, for a total of 48 subjects. Healthy subjects were clerical and maintenance employees who had minimal contact with patients. A second group was medical patients hospitalized with minor medical complaints, such as dermatitis or tonsillitis. The third group was heroin users who were hospitalized for treatment. The fourth group were cancer patients who had been informed of their disease.

Groups were roughly matched in age and race.

#### Instruments and Assessment Measures

The State-Trait Anxiety Inventory (Spielberger, et al., 1968) is comprised of separate self-report scales for measuring two different anxiety concepts: state anxiety and trait anxiety. The STAI trait-anxiety scale consists of 20 statements that asks people to describe ~~how~~ they generally feel. The state anxiety scale also consists of 20 statements, but the instructions require indication of how an individual feels at a particular moment in time. State-anxiety is conceptualized as a transitory emotional state that is characterized by subjective, consciously perceived feelings of tension and apprehension,

and heightened autonomic nervous system activity. Trait-anxiety refers to relatively stable individual differences in anxiety proneness.

Norms are available for large samples of college freshmen, undergraduate college students, and high school students. There are also norms for neuropsychiatric patients, general medical and surgical patients and young prisoners.

Test-retest reliability for trait-anxiety scale are reasonably high with correlations ranging from .73 to .86. State-anxiety correlations were from .16 to .54. Both state and trait scales have a high degree of internal consistency as indicated by alpha reliability coefficients and individual item-remainder correlations.

Concurrent validity was investigated through correlations of STAI trait-anxiety, IPAT Anxiety Scale, and the Taylor Manifest Anxiety Scale; the intercorrelations indicate that the three scales can be considered as alternate measures of trait anxiety.

Evidence of construct validity includes findings that the mean score of state-anxiety scale is considerably higher in threatening conditions than in normal or relaxed conditions (Spielberger, et al., 1968).

The Death Anxiety Scale (Templer, 1970) consists of 15 true-false items selected from an item pool by judgmental rating procedure and computation of point biserial correlations. Internal consistency and test-retest reliability (.83 after three weeks) were determined. The response sets of social desirability and agreement response tendency did not correlate significantly with Death Anxiety Scale score.

Evidence for validity includes findings that high death anxiety psychiatric patients (according to staff and patient's records) had significantly higher Death Anxiety Scale (DAS) scores than control patients. DAS scores for college students correlated significantly with Boyar's FODS scale, another death anxiety questionnaire, and with a sequential word association task.

A sentence completion test designed by the investigator was used to induce anxiety concerning the subject of death.

### Procedure

Sessions were conducted individually and took approximately thirty minutes. The subject was asked to participate in a research project and upon agreement was administered the State-Anxiety Scale to assess initial level of anxiety preceding treatment (pre-measure). The Trait-Anxiety was administered to determine anxiety proneness or usual level of anxiety. Next the examiner explained that the project concerned attitudes toward death; all subjects then agreed to continue and were administered the Death Anxiety Scale (DAS) and the sentence completion test. Immediately following completion of these tasks the state-anxiety measure was re-administered to assess anxiety following treatment (post-measure). Subjects were then given a brief interview to determine whether there was any disturbance which required therapeutic intervention.

## CHAPTER III

### RESULTS

#### Pre-Treatment State-Anxiety Measure

Pre-treatment state-anxiety levels were not significantly different for the four groups. Table 1 summarizes the results of analysis.

#### Trait-Anxiety Measure

Trait-anxiety levels were not significantly different for the four groups. Table 2 summarizes the results of analysis.

#### Post-Treatment State-Anxiety Measure

Post-treatment state-anxiety levels were not significantly different for the four groups. Table 3 summarizes the results of analysis.

#### Change in State-Anxiety Measure Following Treatment

There was no significant difference between groups on change in level of state-anxiety following treatment. There was a slight decrease in anxiety level of the post measure; however, this drop was not significant. All groups with the exception of healthy subjects showed some drop in anxiety from pre to post test. Heroin users showed the greatest drop (-3.90), medical patients showed a drop of -3.25 and the cancer group a drop of -2.50. These differences were not significant. Table 4 summarizes this data.

TABLE I  
SUMMARY OF ANALYSIS OF VARIANCE USING PRE-TREATMENT  
MEASURE MEAN SCORES OF STATE-ANXIETY

Source	df	MS	F
Groups	3	393.92	2.75
Experimental error	44	143.32	

$F_{.95}(3,44)=2.84$



TABLE II  
SUMMARY OF ANALYSIS OF VARIANCE USING  
MEAN SCORES OF TRAIT-ANXIETY

Source	df	MS	F
Groups	3	227.30	2.58
Experimental error	44	88.01	

$P_{95}(3,44)=2.84$

TABLE III  
SUMMARY OF ANALYSIS OF VARIANCE USING MEAN  
SCORES OF STATE-ANXIETY POST TREATMENT

Source	df	MS	F
Groups	3	363.85	2.13
Experimental error	44		

$F_{.95}(3,44)=2.84$

TABLE IV  
SUMMARY OF ANALYSIS OF VARIANCE USING STATE-ANXIETY  
MEAN SCORES AT TIME 1 AND TIME 2

Source	df	MS	F
Groups	3	737.12	2.67
Subjects within groups	44	276.09	
Time	1	110.51	1.16
Time x Group	3	20.65	0.22
Time x subjects within groups	44	95.34	

$P_{95}(3,44)=2.84$

$P_{95}(1,44)=4.08$

### Death Anxiety Scale Measure

There were no significant differences between the groups on scores obtained on the Death Anxiety Scale. Table 5 summarizes this data.

Table 6 is a summary of group means and standard deviations for pre- and post-treatment state-anxiety measure, trait anxiety measure, and Death Anxiety Scale. Table 7 is a summary of the difference between pre- and post-anxiety means for the four groups.

TABLE V  
SUMMARY OF ANALYSIS OF VARIANCE USING  
MEAN SCORES OF DEATH ANXIETY SCALE

Source	df	MS	F
Groups	3	10.04	1.89
Experimental error	44	8.18	
P (3,44)=2.84			

TABLE VI  
 SUMMARY OF GROUP MEANS OF PRE-TREATMENT-STATE ANXIETY,  
 POST-TREATMENT-STATE-ANXIETY, TRAIT-ANXIETY AND DEATH  
 ANXIETY SCALE WITH STANDARD DEVIATIONS

Group	Pre	Post	Trait	DAS
Healthy	38.25 8.97	38.50 12.20	37.33 9.06	6.33 3.19
Medical	37.00 7.79	33.75 7.35	35.50 5.50	6.41 2.52
Heroin	46.75 13.21	42.83 12.59	43.67 8.89	4.75 2.41
Cancer	48.16 12.98	46.50 14.66	44.00 10.27	6.17 2.27
Total	42.54	40.40	40.13	6.33

TABLE VII  
SUMMARY OF POST-ANXIETY MINUS PRE-ANXIETY MEANS

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Healthy	+0.25
Medical	-3.25
Heroin	-3.92
Cancer	-1.66

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### The Hypotheses

In concluding, the results of this research can be applied to the formal hypotheses as follows:

1. For all four groups consideration of the topic of death increases the level of state-anxiety. Not supported; for all four groups there was a slight but insignificant drop in state-anxiety after considering the topic of death.
2. Subjects with different expectancies for personal death regarding time of occurrence will experience different levels of state-anxiety increase with:
  - a. Heroin users--smallest increase. In the predicted direction users showed the greatest drop in anxiety, but the difference was not significant.
  - b. Healthy subjects--increase greater than for heroin group but less than for other groups. Not supported.
  - c. Medical patients--increase greater than for healthy and heroin groups, but less than for cancer patients. Not supported.
  - d. Cancer patients--greatest increase in anxiety. Not supported.
3. Scores on the Death Anxiety Scale will be different for the four groups, with:
  - a. Heroin users--lowest. In the predicted direction, users showed the lowest DAS score, but was not significantly different.
  - b. Healthy subjects--greater than for users, but less than for the other two groups. Not supported.
  - c. Medical patients--greater than for heroin and healthy groups, but less than for cancer patients. Not supported.
  - d. Cancer patients--highest. Not supported.



## CHAPTER IV

### DISCUSSION

#### Experience Collecting Data

Other investigators on this subject have reported great difficulty in obtaining hospital staff and administration's cooperation. Feifel (p. 633, 1965) reported frustrating negative verdicts from hospital administration on various research proposals and concluded that "death is a dark symbol not to be stirred or touched, that it is an obscenity to be avoided." In her work with terminal patients Ross (1969) found staff resistance, overt hostility, and difficulties with resident doctors. Nine out of ten physicians reacted with discomfort, annoyance, overt or covert hostility, when approached for permission to talk with their patients. Nurses originally showed great anger to her project. Like Feifel, she met with the question "Isn't it cruel, sadistic and traumatic to discuss death with seriously and terminally ill people?"

This investigator prepared to meet with the same type of resistance; the material could certainly be seen as potentially threatening and traumatic to patients. However, this resistance never materialized. Initial planning was done with the assistant chief of surgery who was interested, helpful, and felt that the area needed investigation. The research design was approved by the hospital research committee with no questions. Throughout the study, the investigator contacted and dealt with ward doctors, nurses, nurses

aides, medical students, and resident doctors. All were helpful and cooperative; many requested explanations of the research. Several medical students and residents expressed great curiosity, sought discussions, and suggested criticisms and other hypotheses. One resident was very helpful in securing informed cancer patients. This was particularly helpful because locating cancer patients was the most time consuming aspect of the study. The question of whether or how much to tell cancer patients about their illness is a very difficult and controversial area (Oken, 1961; Duff and Hollingshead, 1968; Koenig, 1969; Lund, 1946. Hackett and Weisman (1969) found that cardiac patients are told the truth more often than cancer patients. In this hospital there were no definite policies; most doctors preferred not to tell the patient unless pressed, but did routinely inform some family member; others preferred to tell most of their patients and took time discussing the matter with their patients.

The investigator contacted several cancer patients through the radiologist who informed all the cancer patients of their condition prior to X-ray therapy. Once a resident reported that he felt a young cancer patient should be informed of his condition, but then completed his residency and left before informing his patient. There did seem to be uncertainties about whether to tell the patient, and many times the residents and doctors admitted that this was a difficult chore which they tried to avoid, and at times were unsure just how much the "patient knew." However, no doctor contacted about an informed patient ever refused permission to include the patient in the research.

Therefore, this investigator met with relative openness, cooperation, and not the hostility and resistance others have reported.

The investigator also prepared for the psychological effects which participation in the research might cause patients. A staff psychologist agreed to supervise any crisis intervention which might be necessary if a patient experienced any trauma, depression or anxiety attack after dealing with the research material. It was also expected that some marked percentage of people would refuse to participate in the study. However, neither of these expectations materialized. No follow-up was necessary and no subject refused to participate after learning the topic.

Upon originally approaching the cancer patients, the investigator felt a high degree of anxiety and apprehension, expecting these patients to react with some degree of anger, anxiety, depression, even crying and certainly with some indignation. Expecting to be accused of cruelty and insensitivity the investigator was reluctant to approach these patients. However, contact resulted in different responses from the cancer patients--indifference and nonchalance, interest, flattery, curiosity, humor; one patient grumpily asked what the "silly questions were supposed to prove?" to the investigator's suggestion that maybe he'd rather not participate he replied that he would like to continue.

The initial approaches to organizing the research were made with various staff members in August, 1971. Since that time the investigator has been asked to participate in various seminars with hospital personnel on this subject. Four sessions (four hours for each

session) were conducted by the investigator with nursing assistants. These groups were very eager to talk about care of the dying patient and about their own ideas about death. They also participated in the same research design. The findings were that this group also failed to become anxious about this topic: male nursing assistants state-anxiety mean pre-measure was 40.20; state-anxiety mean post-measure was 39.67 with a Death Anxiety Scale Score of 6.73. Female nursing assistants state-anxiety mean pre-measure was 35.55; post-measure was 42.00 with a DAS mean 7.78. Student nurses state-anxiety mean pre-measure was 33.57, post-measure was 32.31 with a DAS mean 8.07. There were indications, therefore, that women may express more anxiety on the subject and this certainly requires further investigation.

A seminar was also held with nurses and nursing assistants in a one-hour session; they too expressed interest in the subject and had many questions. Seven doctors and 10 medical students took the Death Anxiety Scale; the doctors had a score of 6.8 (range 3-12), the students had a mean of 4.9 (range 1-6). Some doctors express a great deal of anxiety concerning the subject; further investigation is suggested to find out whether there is a relationship between high death anxiety and management of dying patients.

Recently a group of surgeons and surgery residents sought out the investigator to request a seminar on the topic of dealing with the dying patient, with particular interest in how to decide to tell a patient about cancer and what type of management problems to expect.

In general staff, like the subjects of the study, does not

express increased anxiety following consideration of the topic of death. However, investigations by this researcher indicate that this is a difficult area, and staff personnel often feel frustrated, confused, and anxious over dealing with the dying patient and his family. The high rate of asking for seminars and the active participation in these sessions are indicators that it is seen as a problem and the area creates stresses. One hypothesis is that while the subject of death and dying does not provoke high levels of anxiety, required contact with dying patients is stressful. There are many reasons why this might be so; lack of training, feelings of impotence, guilt, ignorance, and uncertainty of what the dying patient is feeling and what he wants. For the staff these feelings may be complicated at times with fear of giving away information to an uninformed dying patient.

#### Lack of Anxiety

The data quite clearly indicated that consideration of the topic of death did not increase state-anxiety as measured by the State-Trait Anxiety Inventory. None of the four groups showed differences in pre-treatment or post-treatment measures or in the change from pre to post measure. There was also no difference between groups on the Death Anxiety Scale. These findings are in disagreement with suggestions by some researchers that patients with a terminal illness become more anxious about death (Cappon, 1962; Feifel and Jones, 1968; and Hinton, 1963). Chandler's (1965) suggestion of three positions of reference toward death was used in designing this study. These positions were:

1. existence of death--awareness that death exists, but is not yet personalized,
2. presence of death--knowledge that one has an

incurable, terminal disease, 3. presentment of death--recognition that death may occur at any moment or that one may live longer than expected. The healthy patients and medical patients were in the first position; the cancer patients were in the second position; and the heroin users were in the third position. However, the data indicated that for these subjects, the position of reference toward personal death had little effect on the level of anxiety aroused by consideration of the subject of death.

The results supported previous findings that "the current attitudes of the 'normal' subjects toward death could be characterized by mild fear in a few and by indifference or concern for others in the rest" (Greenberg, p. 628, 1965). Roberts, et al. (1970) also found that in a study with aged patients only 16% reported any fear of death and only 16% any fear of dying. Twenty percent said they looked forward to death; 35 percent said they never or almost never thought about death and dying. Kastenbaum (1967) found similar data in a group of patients with a mean age of 83; almost half made positive references to death, almost half made neutral references, the rest made negative references (only 1 of 15 men and 2 of 20 women). He (1966) reported having rarely encountered any obvious indication of death fear among aged patients and suggested there is no clear-cut support for believing the aged are afraid of death. Furthermore, he felt that the concept of denial cannot be used to explain these findings.

Several types of explanations for the lack of anxiety found in this study could be made. One possible explanation is that subjects

experienced anxiety increases which they were unable to verbalize. Using psychophysiological methods of assessment, some investigators have found that death-related words elicit greater emotional reactions than neutral words (Alexander, et al., 1957; Meissner, 1958). Another found that mean trials to recognition of words presented with the tachistoscope was greater for death words than for neutral words (Golding, et al., 1966). The suggestion may thus be made that while anxiety was indeed present the subjects were unable to verbalize it, perhaps due to denial or repression. However, the problem in this study was to employ a method of verbally assessing anxiety. Physiological methods are rarely practical for routine assessment by psychologists in a hospital setting.

A second explanation might be that the materials used were not sufficiently threatening to arouse anxiety concerning death. Boyar (1964) was able to increase anxiety by presenting a film which contained death material. Thus, perhaps there is anxiety concerning death which can be aroused in certain situations, and this particular situation was not adequate; only further research can establish this supposition.

The third explanation is that people do not generally exhibit anxiety concerning the subject of death; that it is accepted as an inevitable event. Death is such a definite threat to identity that this idea is difficult to accept. The fact remains that the data of this study largely indicated that the subject was not threatening or disrupting. No subject refused to participate although given the

opportunity to withdraw, and given no pressure to continue. No subject required therapeutic follow-up. One item of the Death Anxiety Scale showed 63 percent of the subjects answered "false" to the statement "I am particularly afraid to die," and 52 percent answered "true" to the statement "I am not at all afraid to die."

#### Examination of the Sentence Completion Test

The sentence completion was examined to determine whether subjects expressed fear of death or aversion to the subject. Two judges (one being the investigator) rated 34 of 48 responses to the stem "Death . . . ." as reflecting acceptance of death. Over-all there was little indication that subjects responded with denial or fear to the sentence stems. In order to more closely examine the sentence completion the investigator devised categories of responses for each stem and then placed each response in the appropriate category. A second judge using the same categories also rated the responses; there were 863 agreements in placing 1008 responses in the categories.

The findings were that in the total sample (48 subjects) at least 50 percent responded with statements expressing:

- acceptance of death (34 Ss)
- would help in an automobile crash (34 Ss)
- religion is meaningful to a dying person (30 Ss)
- his own life had been positive (33 Ss)
- loneliness is bad for a dying person (27)

There were some differences between the four groups; but these differences were not marked and seemed to reflect no significant trends.

An attempt was made by the investigator to determine whether there was any major difference in feeling tone on sentence completion



items. Rating each sentence in terms of the affective tone it seemed to reflect (positive, negative, neutral, and omissions) the following was found:

Groups	Negative	Positive	Neutral	Omissions
Healthy	59	31	129	34
Medical	72	38	125	17
Heroin	69	29	121	32
Cancer	<u>56</u>	<u>37</u>	<u>138</u>	<u>21</u>
	256=25.6%	135=13.3%	513=50.8%	104=10.3%

Once again there seemed to be no significant differences; for this reason no further attempt was made to employ other judges or a more carefully devised rating system. It is interesting, however, that these data also indicate that the four groups had remarkably similar ways of handling this material. The hypothesis might be made that the subject of death is regarded in a generally neutral, even disinterested manner, with some negative feeling about the subject.

#### Death as a Taboo Topic

The most meaningful contribution of this study is on a practical, rather than a theoretical level. The findings indicate that the subject of death is not as painful, and certainly not as anxiety-provoking as many hospital staff personnel believe. Cancer patients were not disturbed by this topic; further research may indicate that such patients welcome the opportunity to discuss the subject. At any rate, the topic may not be as taboo as was previously thought.

There are many hospital policies which are based on protecting

the dying patient from information concerning his illness. In an extensive examination of dying in hospitals, Glaser and Strauss (1965) found that dying patients are kept in a state of closed awareness, not allowed to know about impending death. This is possible because of conditions such as, patients are not experienced at recognizing signs of impending death, doctors do not tell, families guard the secret, hospitals hide medical records, and the patient has no allies to help him get information. The patient may remain at this stage or may move to suspicion awareness, wherein he becomes suspicious about his prognosis; this is, of course, a very unstable stage, and many patients experience psychological stress and distress over the uncertainty.

Preventing the patient from knowing the truth takes a great deal of time, energy, and almost necessitates the wearing of masks and facades by everyone concerned. The whole process may not be necessary. Feifel (1963) found that while 69 to 90 percent of the physicians favor not telling, 77 to 89 percent of the patients want to know; they want to voice their doubts, communicate, and prefer honest, plain talk from physicians and family. Aitken and Easson (1959) studied 231 cancer patients who had been told their diagnosis and found 61 percent of the males and 92 percent of the females approved of having been told; 23 percent of the males and 21 percent of the females denied having been told; no males and 17 percent of the females disapproved of having been told. No unfavorable reaction to being told was observed. The large majority accepted the truth and benefited from the knowledge.

Many problems develop when information is withheld. Gerle and Sanblom (1960) found that patients who were not informed were the most difficult to work with. They were anxious and desperate because in spite of increasing symptoms there was no help from the hospital. Financial mistakes were made and families complained of strain. Thirty-eight patients who knew their prognosis engaged in no wild excesses and reported that home relations improved.

The present research indicated that people, even cancer patients, may have a much more casual, accepting attitude toward death and dying than most professionals believe. Perhaps further research could indicate the usefulness of more openness on this subject.

#### Critique and Suggestions for Further Research

Speculation on changes in design which could produce positive results indicated several variables which could be more rigorously controlled. Perhaps the most significant is nearness to death for the cancer patients. Lieberman (1966) studying aged patients found distance from death the most powerful arrangement for observing psychological changes. The best arrangement for this type study would be to approach the cancer patients within a few days after the doctor had informed them of their conditions. In the present study this variable was totally uncontrolled; some patients were approached days after being informed, some after months, and for most this was an unknown variable.

Another change might be a more rigorous control of age of the subjects. Mean ages were healthy 35.92, medical 35.50, heroin 31.17, cancer 46.91.

Other variables which could be controlled in further studies of this nature are religiosity, education, marital status, occurrence of death in immediate family, occupation.

One further improvement would be increased number of subjects in each group. Availability of cancer patients under the age of 60 years in the Veterans Hospital made the small sample size a practical necessity; however, larger subject pools could be obtained in cancer hospitals or even in large hospitals with cancer wards.

Information is needed which could help the decision-making process concerning whether to tell dying patients of their conditions. A longitudinal study of patients who are informed and patients who are not informed about terminal disease, followed from the point in time when they were told to the point of coma or death, in terms of change in anxiety and personality characteristics would be a very significant study.

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## A P P E N D I X

Complete these sentences to express your real feelings. Try to do every one.

1. Dying of cancer
2. When I die I will not be able to
3. The pain of dying
4. Death
5. If I witnessed an automobile crash with bleeding and dying people
6. To a dying person religion
7. The best way to die
8. For a dying person being alone
9. My life has been
10. I would rather die than
11. Talking about death
12. Whenever I think about my own death
13. Loneliness is
14. My greatest fear
15. Funerals
16. Dying people
17. Life after death
18. Time passes
19. Death is welcome to a person who
20. Mourning
21. These questions

Please read the statements below. If the statement is true for you circle T; if the statement is false for you circle F. Please answer all the statements.

- |   |   |   |
|---|---|---|
| 1. I am very much afraid to die.                                | T | F |
| 2. The thought of death seldom enters my mind.                  | T | F |
| 3. It doesn't make me nervous when people talk about death.     | T | F |
| 4. I dread to think about having to have an operation.          | T | F |
| 5. I am not at all afraid to die.                               | T | F |
| 6. I am not particularly afraid of getting cancer.              | T | F |
| 7. The thought of death never bothers me.                       | T | F |
| 8. I am often distressed by the way time flies so very rapidly. | T | F |
| 9. I fear dying a painful death.                                | T | F |
| 10. The subject of life after death troubles me greatly.        | T | F |
| 11. I am really scared of having a heart attack.                | T | F |
| 12. I often think about how short life really is.               | T | F |
| 13. I shudder when I hear people talking about a World War III. | T | F |
| 14. The sight of a dead body is horrifying to me.               | T | F |
| 15. I feel that the future holds nothing for me to fear.        | T | F |

## VITA

Pamela Reynolds Hoblit was born in Centreville, Mississippi, on April 26, 1945, the oldest of four children born to J. Edward and Lucy Reynolds. She graduated from Baton Rouge High School in 1963. From 1963 to 1966 she attended Louisiana State University and earned a B.A. degree. She attended the University of Georgia in Athens, Georgia from 1966 to 1967 and graduated with a M.S. degree.

She was married to Paul Hoblit in 1967 and has one child, Jason.

Doctoral work was begun at Louisiana State University in 1968, and she had a NDEA stipend from 1968-1969, and was a USPHS Fellow from 1969-1970. An internship was completed at the Veterans Administration Hospital in New Orleans in 1971. She is currently a VA trainee and is a candidate for the Doctoral degree in Clinical Psychology during the 1972 Spring Commencement.

## EXAMINATION AND THESIS REPORT

Candidate: Pamela Reynolds Hoblit

Major Field: Psychology

Title of Thesis: An Investigation of Changes in Anxiety Level Following  
Consideration of Death in Four Groups

Approved:

Jessie G. Dawson  
Major Professor and Chairman

Max Goodrich  
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Date of Examination:

March 10, 1972